ForwardHealth Portal

HMO EOB Cheat Sheet

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Document Navigation

Option 1: Search for the EOB Code using search features.

Option 2: Search for the Edit/Error Code using search features.

Option 3: Use Bookmarks functionality in your PDF viewer.

EOB	Description
0025	Billing or rendering provider enrollment is no longer enrolled for the From and/or To Date of Service.
0029	Last name does not match member ID.
0051	The header from and to dates of service cannot be the same.
0080	Diagnosis code submitted does not indicate medical necessity or is not appropriate for service billed.
0100	Denied as a duplicate claim.
0116	Procedure code or drug code not a benefit on date of service.
0175	Rendering provider indicated is not certified as a rendering provider.
0205	Detail Rendering Provider is no longer enrolled for the Date of Service
0221	The detail billed amount is required.
0273	Resubmit charges for ForwardHealth covered service(s) denied by Medicare on a ForwardHealth claim.
0278	Member is covered by commercial health insurance on the date(s) of service.
0363	This obstetrical service was previously paid for this date of service for this member.
0378	Tooth number or letter is not valid with the procedure code for date of service.
0424	Billing provider ID is not on file.
0477	Billing provider indicated is not certified as a billing provider.
0558	The service requested is not allowable for the diagnosis indicated.
0614	First name does not match member ID.
0656	A diagnosis code of greater specificity must be used for the first diagnosis code.
0657	A diagnosis code of greater specificity must be used for the second diagnosis code.
0664	A diagnosis code of greater specificity must be used for the third diagnosis code.
0668	A diagnosis code of greater specificity must be used for the fourth diagnosis code.
0669	A diagnosis code of greater specificity must be used for the fifth diagnosis code.
0679	The surgical procedure code of greatest specificity must be used.
0697	The number of tooth surfaces indicated is insufficient for the procedure billed.
0749	Routine foot care diagnoses must be billed with valid routine foot care procedure codes.
0807	Diagnosis code indicated is not valid as a primary diagnosis.
0860	A diagnosis code of greater specificity must be used for the sixth diagnosis code.
0861	A diagnosis code of greater specificity must be used for the seventh diagnosis code.
0862	A diagnosis Code of greater specificity must be used for the eighth diagnosis code.
0863	A diagnosis code of greater specificity must be used for the ninth diagnosis code.

EOB	Description
0901	The from date of service and to date of service must be in the same calendar month and year.
0941	This procedure code and billed charge were rebundled to another code, which was either billed by the provider on this claim or added by ClaimCheck.
0962	Member does not have commercial health insurance for the date(s) of service.
1012	A patient status code indicating the member has expired is required when an occurrence code representing the members date of death is submitted. Or, The occurrence code for member date of death is not allowed to be billed as a span code
1014	Service Denied due to 'N' financial indicator
1103	The number of covered days is required.
1116	The revenue code requires an appropriate corresponding procedure code.
1128	A tooth number or letter is required.
1145	Area of the oral cavity is required for procedure code.
1198	A National Drug Code (NDC) is required for this HCPCS Code.
1204	Billing provider is not certified for the date(s) of service.
1238	The rendering provider's taxonomy code in the header is invalid.
1256	Member is enrolled in Medicare Part A on the date(s) of service.
1257	Member is enrolled in Medicare Part B on the date(s) of service.
1260	The sum of the accommodations days is not equal to the sum of covered plus non-covered days.
1270	The header total billed amount is required and must be greater than zero.
1271	The total billed amount is missing or incorrect.
1275	Quantity billed is restricted for this procedure code.
1290	Type of bill is invalid for the claim type.
1306	Add-on codes are not separately reimbursable when submitted as a stand-alone code.
1347	Billing provider number is not found or not valid for dates of service.
1374	A diagnosis of greater specificity must be used for the diagnosis code in positions 10 through 24.
1455	Service (Procedure Code/Modifier Combination) is not reimbursable for Date of Service.
1491	The attending provider's taxonomy code in the header is invalid.
1504	Performing provider number is not found.
1505	The billing provider's taxonomy code in the header is invalid.
1519	The Primary Diagnosis Code is inappropriate for the Procedure Code
1531	Indicator for present on admission (POA) is not a valid value.
1566	Denied/Cutback. One BMI Incentive payment is allowed per member, per rendering provider, per calendar year.
1599	Header rendering provider used as billing provider.
1644	Valid other payer date required.
1649	Revenue code requires submission of associated HCPCS Code.
1652	HMO hierarchy logic used to determine service location.
1665	Unable to processes your adjustment request. Member ID not present.
1667	Unable to processes your adjustment request. Provider ID not present.

EOB	Description
1668	Unable to processes your adjustment request. Claim ICN not found.
1669	Unable to process your adjustment request. Original ICN not present.
1670	Unable to processes your adjustment request. Member not found.
1671	Unable to processes your adjustment request. Provider not found.
1672	Unable to process your adjustment request. Original claim ICN not found.
1673	Unable to process your adjustment request. Claim has already been adjusted.
1677	Unable to process your adjustment request. The claim type of the adjustment does not match the claim type of the original claim.
1678	Unable to processes your adjustment request. Member ID number on the claim and on the adjustment request do not match.
1679	Unable to processes your adjustment request. Provider ID number on the claim and on the adjustment request do not match.
1685	Billing provider type and specialty is not allowable for the place of service.
1686	This service is not payable with another service on the same date of service due to National Correct Coding Initiative.
1690	Quantity indicated for this service exceeds the maximum quantity limit established by the National Correct Coding Initiative.
1691	This service is not payable for the same date of service as another service included on the same claim, according to the National Correct Coding Initiative.
1705	HMO hierarchy logic used to determine service location for detail rendering provider.
1824	HMO ID is invalid or not present on encounter claim.
3012	This service cannot be performed in an outpatient hospital setting.
3018	Detail denied because a related significant procedure and/or medical visit was denied for the same visit.
3019	Services for this date of service have been previously paid. Providers may adjust a previously paid claim for this date of service to request reimbursement for additional services provided during the same outpatient hospital visit.
3041	Submitting HMO is not the enrolled HMO of the member.
3048	Manifestation diagnoses cannot be used as the principal diagnosis.
3050	A more specific diagnosis code is required for this detail.
3051	Nonspecific diagnosis codes cannot be used.
3052	Nonspecific ICD procedure codes cannot be used.
3059	ForwardHealth reimburses behavioral treatment services under this procedure code only when commercial insurance has previously allowed payment on the service. Resubmit this claim with the appropriate commercial insurance payment amount. If commercial insurance did not reimburse for this service, use the appropriate ForwardHealth-covered procedure code.
3064	Services performed outside the four walls of a hospital are not reimbursable on an outpatient claim.
8188	MASS ADJUSTMENT – VOID TRANSACTIONS.
9817	Billing provider number was used to adjudicate the service(s).
9955	Member is not enrolled in managed care.
9956	Services have been carved out of HMO encounter processing.

EOB 0116 Procedure code or drug code not a benefit on date of service.

The following EOBs often post with EOB 0116. Other EOBs may also post. Note that the fact the EOB posts means there are restrictions, not necessarily that the restrictions were not met. Each encounter is evaluated using the steps below.

0182 Billing Provider Type and/or Specialty is not allowable for the service billed.
0184 Procedure Code is restricted by member age.
0229 The Type of Bill is invalid.
0770 The Revenue Code is not allowed for the Type of Bill indicated on the claim.
0859 Modifiers submitted are invalid for the Date of Service or are missing.
1279 Procedure not payable for Place of Service.
1280 Rendering Provider Type and/or Specialty is not allowable for the service billed.
1521 Procedure Code is not allowed on the claim form/transaction submitted.
1522 ICD Procedure Code is not allowed on the claim form/transaction submitted.
1554 The Claim Type and Diagnosis Code submitted are not payable.
3020 Billing Provider Type and/or Specialty is not allowable for the revenue code billed

EOB 0116 sets with Edit 3363 NO PROCEDURE REIMBURSEMENT RULE FOR CLAIM REGION
EOB 0116 also sets with Edit 4801 NO BILLING RULE FOR PROCEDURE
EOB 0116 also sets with Edit 4804 NO BILLING RULE FOR REVENUE CODE
EOB 0182 sets with Edit 4149 BILLING PT/PS RESTRICTION ON PROC BILLING RULE
EOB 0184 sets with Edit 4714 AGE RESTRICTION ON PROC BILLING RULE
EOB 0229 sets with Edit 274 TYPE OF BILL CODE INVALID
EOB 0229 sets also sets with Edit 802 FREQUENCY CLAIM TYPE INVALID
EOB 0770 sets with Edit 4874 CLAIM TYPE RESTRICTION ON REV CODE BILLING RULE
EOB 0859 sets with Edit 4257 MODIFIER RESTRICTION FOR PROC BILLING RULE
EOB 1279 sets with Edit 4821 PLACE OF SERVICE RESTRICTION ON PROC BILLING RULE
EOB 1280 sets with Edit 4150 PERF/FACILITY PT/PS RESTRICTION PROC BILLING RULE
EOB 1521 sets with Edit 4871 CLAIM TYPE RESTRICTION ON PROC BILLING RULE
EOB 1522 sets with Edit 4876 CLAIM TYPE RESTRICTION ON ICD PROC BILLING RULE
EOB 1554 sets with Edit 4314 CLAIM TYPE RESTRICTION ON DIAG CVG RULE
EOB 3020 sets with Edit 4151 BILLING PT/PS RESTRICTION ON REV CODE BILLING RULE

Note: Effective with date of submission 6/15/2015, additional provider logic was implemented for EOB 0182/Edit 4149, EOB 1280/Edit 4150, EOB 0859/Edit 4257, EOB 0184/Edit 4714, EOB 0116/Edit 4801, and EOB 1521/Edit 4871 . Please refer to "Section 5.8.3: Provider Procedure Billing Rule Hierarchy Logic" of the *Encounter User Guide* for additional information.

Step 1 – Check for Known Non-covered Procedures or Drug Codes

A non-covered service is a service, item, or supply for which reimbursement is not available. DHS 101.03(103) and 107, Wis. Admin. Code, contains more information about non-covered services. In addition, DHS 107.03, Wis. Admin. Code contains a general list of non-covered services.

Check the Online Handbooks. If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME delivery charges are included in the

reimbursement for DME items.
(Topic #51 Online Handbook)

Coverage for Medicaid non-covered services is limited to Medicare copay/deduction reimbursement for a Medicare covered service.

Step 2 – Check Transaction Type

Consult the Online Provider Handbook at:
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx for information.

- Choose a Program: BadgerCare Plus and Medicaid → Choose a service area → Select Claims → Submission → Electronic Claim Submission.

Electronic claims for dental services must be submitted using the 837D transaction. Electronic claims for dental services submitted using any transaction other than the 837D will be denied.
(Topic #2684 Online Handbook)

Electronic claims for hospital services must be submitted using the 837I transaction. Electronic claims for inpatient hospital services submitted using any transaction other than the 837I will be denied.
(Topic #1433 Online Handbook)

Electronic claims for physician/professional services must be submitted using the 837P transaction. Electronic claims for physician services submitted using any transaction other than the 837P will be denied.
(Topic #641 Online Handbook)

Step 3 – Check Encounter Type

The encounter type is determined by the X12 Transaction Type and the "Type of Bill." (See EOB 1290 for more information). For Transaction Types 837P and 837I, consider the member's Medicare status. For example, if the member has Medicare A on the DOS, the encounter type will be an Inpatient Crossover. Medicare adjudication must be included. See EOBs 1256 and 1257.

Claim Form	X12 Transaction Type	Encounter Type	Type Description
Dental	837D	D	Dental Claims
Professional	837P	M B	Professional Professional Crossover
Institutional	837I	I O A C H L	Inpatient Outpatient Inpatient Crossover Outpatient Crossover Home Health Long Term Care

Step 4 – Determine the Billing Provider

Billing providers must be certified as a 'Biller' or a 'Biller and Performer'. Providers certified only as a 'Performer' but submitted as a billing provider will cause the encounter to deny.

Note that a provider's certification is not always consistent among different taxonomies for the same NPI. For providers with multiple taxonomies, HMOs should ensure the taxonomy submitted matches a provider with valid certification. Note also that PT/SP differs for the same NPI.

Billing providers must have valid contracts and certification for the DOS.

Step 5 – Determine the Rendering Provider

Rendering providers must be certified as a 'Performer' or a 'Biller and Performer'. Providers certified only as a 'Biller' but submitted as a rendering provider will cause the encounter to deny.

Note that a provider's certification is not always consistent among different taxonomies for the same NPI. For providers with multiple taxonomies, HMOs should ensure the taxonomy submitted matches a provider with valid certification. Note also that PT/SP differs for the same NPI.

Rendering providers must have valid contracts and certification for the DOS.

Note on Provider Propagation Logic
In some cases a billing provider is considered the rendering provider even if a separate rendering provider is submitted. In such cases, the rendering provider submitted is not used to price the encounter. Similarly, if a separate rendering provider is not submitted, the billing provider is also considered the rendering provider. In this case, the billing provider must be a 'Biller and Performer'.

See "Section 5.7: Provider Propagation Logic" in the *Encounter User Guide* for more information

Step 6 – Determine Restrictions

Consult the Online Handbook at:
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx for information.

- Choose a Program: BadgerCare Plus and Medicaid → Choose a service area → Select Covered and Noncovered Services → Codes → All Information

Example 1: Dental service area
Note restrictions for drugs, procedures, procedure modifiers, dental hygienist allowable services, diagnosis codes, and POS codes.

Example 2: Hospital, Inpatient service area
Note restrictions for diagnosis codes, procedure codes, and revenue codes.

Example 3: Outpatient Mental Health service area
Note restrictions for diagnosis, POS, procedure, professional level and other modifiers, and revenue codes.

Step 7 – Max Fee Schedule

Online Handbook restrictions may refer the user to the max fee schedule.

Consult the procedure restrictions at:
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeSearch.aspx

- Select a Financial Payer (Medicaid) and Service Area from the drop down lists.
- Enter the procedure code in question.
- Use the Date of Service field to see the active rules for at a specific time.

Tip: Initial search results only show "Billing Rules". Use the links at the bottom of the page to navigate to a procedure code's "Max Fee Rates" and "Restrictions", or select "Show All".

Max Fee Search Example:
Financial Payer: Medicaid
Service Area: MENTAL HEALTH - MENTAL HEALTH AND MENTAL HEALTH FOR ALCOHOL AND OTHER DRUG ADDICTIONS
Procedure Code: 96150
DOS 8/1/2016.

Billing Rules

- This section displays billing restrictions on the procedure code for the select service area.

Rendering Provider Type/Specialty	Modifiers	Place of Service	PA Always Required	Diagnosis Restriction	Benchmark/Core/Basic Indicator
11/125, 11/801, 11/802, 11/803, 31/339, 33/339	UA, UB one is present	03, 04, 05, 06, 07, 08, 11, 15, 19, 20, 21, 22, 23, 26, 31, 32, 33, 49, 50, 51, 52, 53, 54, 56, 61, 62, 71, 72, 99	No	Yes	Basic/Core
11/080, 11/112, 11/117, 11/120, 11/121, 11/123, 11/124, 11/125, 11/801, 11/802, 11/803, 31/339	HO, HP, U6, UA, UB one is present	03, 04, 05, 06, 07, 08, 11, 15, 19, 20, 21, 22, 23, 26, 31, 32, 33, 49, 50, 51, 52, 53, 54, 56, 61, 62, 71, 72, 99	No	Yes	Benchmark/Benchmark Dental
11/126		03, 04, 05, 06, 07, 08, 11, 15, 19, 20, 21, 22, 23, 26, 31, 32, 33, 49, 50, 51, 52, 53, 54, 56, 61, 62, 71, 72, 99	No	Yes	Benchmark/Benchmark Dental

Max Fee Rates

- This section displays the maximum allowable rate payable for the selected service area and procedure code.

Rendering Provider Type/Specialty	Modifiers	Rate	Age (Min/Max)	Rate Type	Benchmark/Core/Basic Indicator
excluding 11/126	UA	20.23	N/A	C32	Benchmark/Benchmark Dental/Core/Basic
excluding 11/126	HP	16.41	N/A	C32	Benchmark/Benchmark Dental/Core/Basic
excluding 11/126	HO	13.89	N/A	C32	Benchmark/Benchmark Dental/Core/Basic
excluding 11/126	U6	11.11	N/A	C32	Benchmark/Benchmark Dental/Core/Basic
excluding 11/126	UB	13.89	N/A	C32	Benchmark/Benchmark Dental/Core/Basic
11/126		11.11	N/A	QTT	Benchmark/Benchmark Dental/Core/Basic

Note the Modifier and Place of Service (POS) restrictions for Rendering Provider Type/Specialty (PT/SP).

Note the financial impact of each modifier. Note also that there are Diagnosis restrictions. See EOB 0080.

EOB 1455 Service (Procedure Code/Modifier Combination) is not reimbursable for Date of Service.

EOB 1455 sets with Edit 4209 NO PRICING SEGMENT FOR PROCEDURE/MODIFIER COMB

EOB 1455 sets when a detail procedure/modifier code combination billed cannot find a single, matching Max Fee rate on file.

Check the modifier

EOB 1455 can set if a detail procedure is billed with two or more mutually exclusive modifiers. For example, Forwardhealth reimburses the narcotics treatment service H0020 [METHADONE ADMINISTRATION AND/OR SERVICE] based on the level of care modifier present (U1, U2, U3, or U4). If H0020 was billed with both modifiers U1 and U2, the service would deny.

Contract Code	Contract Name	Procedure Code	PT/PS List	Pricing Indicator	Max Fee Modifiers	Rate
MHNTS	Mntl Hlth-Narc Trtmt	H0020	I~52/160;52/161	MAXFEE	U1	12.19
MHNTS	Mntl Hlth-Narc Trtmt	H0020	I~52/160;52/161	MAXFEE	U2	32
MHNTS	Mntl Hlth-Narc Trtmt	H0020	I~52/160;52/161	MAXFEE	U3	90.64
MHNTS	Mntl Hlth-Narc Trtmt	H0020	I~52/160;52/161	MAXFEE	U4	81.57

***Note**: Rates listed are for example only. Please refer to Forwardhealth for the most up-to-date rates:*

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeHome.aspx

EOB 1290 Type of bill is invalid for the claim type.

EOB 1290 sets with Edit 801 TYPE OF BILL/CLAIM TYPE INVALID

Check Official UB-04 Data Specifications Manual or Online Handbook.

The UB-04 manual includes restrictions on Type of Bill (TOB) codes.

Information is also available in the Online Handbook at:
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx.

- Choose a Program: BadgerCare Plus and Medicaid → Choose a service area → Select Claims → Submission → UB-04…

Example:
Home Health service area → Select Claims → Submission → UB-04 (CMS 1450) Claim Form Instructions for Home Health Services.

The TOB is a 3-digit code. The first digit identifies the type of facility, i.e. Hospital, Skilled Nursing, or Home Health. The second digit classifies the type of care, and the third digit indicates the billing frequency. On the 837I transaction, the TOB is made up of values CLM05-1 and CLM05-3.

In this example, the TOB is 111:

CLM*8929694*8188***11>A>1**A*Y*Y~

The 837I claim type is technically determined in the EDI translation map from the facility type code, which is part of the type of bill (TOB), and which is found in sub-element CLM05-1 on the 837I X12 transaction. The four claim types are I (inpatient), O (outpatient), H (home health), and L (long-term care). The claim type is assigned based on the facility type code as follows:

- Claim type H: facility type code 32, 34.
- Claim type I: facility type codes 11, 15-18.
- Claim type L: facility type codes 21, 25-28.
- Claim type O: facility type codes 12-14, 19, 22-24, 29, 31, 32, 34-39, 41-49, 51-59, 61-69, 71-79, 81-89, 91-99.

If a facility type code other than those listed above is received on the X12 transaction, claim type O is assigned by default.

Note: If the claim is determined to be a Medicare crossover claim, then claim types I and L are changed to claim type A, and claim types H and O are changed to claim type C.

To ensure a priced encounter, please use the guidelines (summary below) found in the Online Handbook for TOB restrictions:

- Claim Type H: 321 – 324 for Care Under the Treatment Plan; 341 – 344 for Care Not Under the Treatment Plan
- Claim Type I: 111, 851 (Critical Access Hospital)
- Claim Type L: 211 – 214
- Claim Type O: 131, 851 (Critical Access Hospital), 721 (ESRD).

EOB 0080 Diagnosis code submitted does not indicate medical necessity or is not appropriate for service billed.

AND/OR

EOB 0558 The service requested is not allowable for the diagnosis indicated.

AND/OR

EOB 1519 The Primary Diagnosis Code is inappropriate for the Procedure Code

EOB 0080 sets with Edit 3373 DIAG HDR ANY GROUP RSTCN FOR PROC BILLING RULE
EOB 0080 also sets with Edit 3374 DIAG HDR ANY GROUP RSTCN FOR REV BILLING RULE
EOB 0080 also sets with Edit 4315 ANY HDR DIAG RSTCN FOR PROC BILLING RULE
EOB 0080 also sets with Edit 4322 ANY HDR DIAG RSTCN FOR REV BILL RULE
EOB 0558 sets with Edit 3369 DIAG DTL ANY GROUP RSTCN FOR PROC BILLING RULE
EOB 1519 sets with Edit 3375 DIAG HDR PRIMARY GROUP RSTCN FOR PROC CVG RULE
EOB 1519 also sets with Edit 3377 DIAG HDR PRIMARY GROUP RSTCN FOR PROC BILLING RULE
EOB 1519 also sets with Edit 3379 DIAG DTL PRIMARY GROUP RSTCN FOR PROC CVG RULE

Check Units Per Day & Diagnosis Restriction Report.

This report includes restrictions on procedure codes that include:

- Units allowed per date of service
- Diagnosis codes that must/must not be present when the procedure code is billed
- Procedure and/or revenue codes that must be billed with the service for it to be a covered

Search the report by Procedure Code. Note that the procedure may be listed under more than one contract. Select the applicable contract. Note restrictions for Claim Type, POS, Units per Day, Diagnosis Header Any, and Diagnosis Detail Any. Effective dates for the restrictions are also included.

For example, Search for Procedure 96153 under the MHAOD contract. Note the Diagnosis Header Any restrictions. Any header diagnosis that does not meet the restrictions will cause the encounter to deny.

The *Units per Day & Diagnosis Restriction Report* is published quarterly to the FTP server.

Consult the HMO Report Matrix for more information on this report and others at: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage.

EOB 0749 Routine foot care diagnoses must be billed with valid routine foot care procedure codes.

EOB 0749 sets with Edit 3330 ROUTINE FOOT CARE PROCEDURES

Professional encounters with:

Place of Service (POS)	1, 3, 4, 5, 6, 7, 8, 9, 11, 12, 14, 15, 19, 20, 21, 22, 23, 25, 26, 31, 32, 33, 34, 49, 50, 51, 54, 56, 57, 60, 61, 71, 72, or 99
Billing Provider Contract	Medical Services (MEDSV)
Billing Provider Type/Specialty	14/000
Procedure Codes	11000: DEBRIDE INFECTED SKIN 11040: DEBRIDE SKIN, PARTIAL 11041: DEBRIDE SKIN, FULL 11042: DEB SUBQ TISSUE 20 SQ CM/< 11043: DEB MUSC/FASCIA 20 SQ CM/< 11720: DEBRIDE NAIL 1-5 11721: DEBRIDE NAIL 6 OR MORE

Are restricted for the following ICD 9 diagnosis codes:

ICD-9 Dx Range From	ICD-9- Dx Range To
2506	2508
335	336
337	337
340	3419
343	3439
3441	3441
353	3539
355	3579
4409	4409
443	4439

And the ICD 10 diagnosis codes on the next page:

ICD-10 Dx Range From	ICD-10- Dx Range To
A5215	A5215
E0800	E089
E093211	E093211
E093212	E093212
E093213	E093213
E093219	E093219
E093311	E093311
E093312	E093312
E093313	E093313
E093319	E093319
E093411	E093411
E093412	E093412
E093413	E093413
E093419	E093419
E093511	E093511
E093512	E093512
E093513	E093513
E093519	E093519
E09352	E09352
E093521	E093521
E093522	E093522
E093523	E093523
E093529	E093529
E09353	E09353
E093531	E093531
E093532	E093532
E093533	E093533
E093539	E093539
E09354	E09354
E093541	E093541
E093542	E093542
E093543	E093543
E093549	E093549
E09355	E09355
E093551	E093551
E093552	E093552
E093553	E093553
E093559	E093559
E093591	E093591
E093592	E093592
E093593	E093593
E093599	E093599
E0937	E0937
E0937X1	E0937X1

ICD-10 Dx Range From	ICD-10- Dx Range To
E0937X2	E0937X2
E0937X3	E0937X3
E0937X9	E0937X9
E0940	E0942
E0944	E0944
E0951	E0952
E1010	E139
G041	G041
G1220	G1229
G130	G131
G320	G320
G35	G379
G540	G545
G548	G55
G5700	G5702
G5781	G5782
G5791	G5792
G588	G652
G800	G802
G804	G8383
G8389	G839
G8921	G8928
G893	G9009
G904	G904
G90521	G90523
G950	G959
G990	G992
H540	H540
H540X33	H540X33
H540X34	H540X34
H540X35	H540X35
H540X43	H540X43
H540X44	H540X44
H540X45	H540X45
H540X53	H540X53
H540X54	H540X54
H540X55	H540X55
H5411	H543
H54413A	H54413A
H54414A	H54414A
H54415A	H54415A
H5442A3	H5442A3
H5442A4	H5442A4

EOB 0656 A diagnosis code of greater specificity must be used for the first diagnosis code.

OR

EOB 0657 A diagnosis code of greater specificity must be used for the second diagnosis code.

OR

EOB 0664 A diagnosis code of greater specificity must be used for the third diagnosis code.

OR

EOB 0668 A diagnosis code of greater specificity must be used for the fourth diagnosis code.

OR

EOB 0669 A diagnosis code of greater specificity must be used for the fifth diagnosis code.

OR

EOB 0860 A diagnosis code of greater specificity must be used for the sixth diagnosis code.

OR

EOB 0861 A diagnosis code of greater specificity must be used for the seventh diagnosis code.

OR

EOB 0862 A diagnosis Code of greater specificity must be used for the eighth diagnosis code.

OR

EOB 0863 A diagnosis code of greater specificity must be used for the ninth diagnosis code.

OR

EOB 1374 A diagnosis of greater specificity must be used for the diagnosis code in positions 10 through 24.

EOB 0656 sets with Edit 4891 DISCHARGE DIAGNOSIS CODE 1 ICD SPECIFICITY
EOB 0657 sets with Edit 4892 DISCHARGE DIAGNOSIS CODE 2 ICD SPECIFICITY
EOB 0664 sets with Edit 4893 DISCHARGE DIAGNOSIS CODE 3 ICD SPECIFICITY
EOB 0668 sets with Edit 4894 DISCHARGE DIAGNOSIS CODE 4 ICD SPECIFICITY
EOB 0669 sets with Edit 4895 DISCHARGE DIAGNOSIS CODE 5 ICD SPECIFICITY
EOB 0860 sets with Edit 4896 DISCHARGE DIAGNOSIS CODE 6 ICD SPECIFICITY
EOB 0861 sets with Edit 4897 DISCHARGE DIAGNOSIS CODE 7 ICD SPECIFICITY
EOB 0862 sets with Edit 4898 DISCHARGE DIAGNOSIS CODE 8 ICD SPECIFICITY
EOB 0863 sets with Edit 4899 DISCHARGE DIAGNOSIS CODE 9 ICD SPECIFICITY
EOB 1374 sets with Edit 4890 DISCHARGE DIAGNOSIS CODE 10-24 ICD SPECIFICITY

These EOBs display if a submitted diagnosis code is not specific enough.

For example, of the following ICD-10-CM Diagnosis Codes M65 is not acceptable, but M6500, M65011 and M65032 are acceptable. These three codes are all more specific, descriptive forms of the M65 diagnosis.

- M65 SYNOVITIS AND TENOSYNOVITIS
- M6500 ABSCESS OF TENDON SHEATH, UNSPECIFIED SITE
- M65011 ABSCESS OF TENDON SHEATH, RIGHT SHOULDER
- M65032 ABSCESS OF TENDON SHEATH, LEFT FOREARM

Outpatient, Outpatient Crossover, Home Health, Inpatient Crossover (Long Term Care) and Long Term Care claim types use FROM DATE OF SERVICE.

Inpatient and Inpatient Crossover (non-Long Term Care) claim types use TO DATE OF SERVICE.

EOB 3051 Nonspecific diagnosis codes cannot be used.

EOB 3051 sets with Edit 3407 NONSPECIFIC DIAGNOSIS CODE

EOB 3051 sets on inpatient and inpatient (non-long term care) crossover claim types if any header diagnosis codes are nonspecific (have a nonspecific indicator of 'Y' [yes]).

EOB 3050 A more specific diagnosis code is required for this detail.

EOB 3050 sets with Edit 3404 DETAIL DIAGNOSIS GREATER SPECIFICITY REQUIRED

EOB 3050 sets on professional and professional crossover claim types if any of the detail diagnosis pointers point to a nonspecific diagnosis code (code with nonspecific indicator of 'Y' [yes] on the FDOS).

EOB 3048 Manifestation diagnoses cannot be used as the principal diagnosis.

EOB 3048 sets with Edit 3398 PRINCIPAL DTL DIAG CANNOT BE MANIFESTATION

EOB 3048 sets on professional, professional crossover, and dental claim types if the detail diagnosis pointer in the first position points to a diagnosis code with a manifestation indicator of 'Y' (yes).

Manifestation indicates whether a diagnosis code describes the manifestation of an underlying disease, not the disease itself, and therefore cannot be a principal diagnosis. These codes cannot be billed alone, instead they must be reported with the code for the underlying disease.

The manifestation editing in the system is based on manifestation codes that have been set at a national level.

EOB 0807 Diagnosis code indicated is not valid as a primary diagnosis.

EOB 0807 sets with Edit 4039 DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS

EOB 0807 sets on outpatient, outpatient crossover, home health, long-term care (LTC) and LTC inpatient crossover claim types if the primary diagnosis has a manifestation indicator of 'Y' (yes) for the FDOS.

EOB 0807 sets on inpatient and inpatient crossover (non LTC) claim types if the primary diagnosis principal value is 'N' (no) and/or if the principal diagnosis has a manifestation indicator of 'Y' (yes) on the detail TDOS.

Manifestation indicates whether a diagnosis code describes the manifestation of an underlying disease, not the disease itself, and therefore cannot be a principal diagnosis. These codes cannot be billed alone, instead they must be reported with the code for the underlying disease.

The manifestation editing in the system is based on manifestation codes that have been set at a national level.

EOB 1116 The revenue code requires an appropriate corresponding procedure code.

OR

EOB 1649 Revenue code requires submission of associated HCPCS Code.

EOB 1116 sets with Edit 3896 PROCEDURE RSTCN FOR REV BILL RULE EOB 1649 sets with Edit 4088 REVENUE CODE REQUIRES HCPCS FOR TYPE OF BILL

EOB 1116 displays if the submitted procedure code does not meet revenue code restrictions.

EOB 1649 displays when a procedure code is not submitted when required to meet revenue code restrictions.

Consult the Online Handbook at:
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx for information.

- Choose a Program: BadgerCare Plus and Medicaid → Choose a service area → Select Covered and Noncovered Services → Codes → Revenue Codes

Example Hospital, Outpatient service area:
A list of outpatient hospital revenue codes that are exempt from the requirement to have a corresponding HCPCS or CPT is included.

Check The Outpatient Restriction Extract.

This extract contains two pipe-delimited .csv files that outline the billing rules for the Outpatient (OUTPA) provider contract, one for procedure codes and one for revenue codes.

The extract includes:

- Procedure restrictions on revenue codes
- Billing and performing provider type/specialty restrictions
- Gender, age, modifier, claim type, and other restrictions.

The Outpatient Restriction Extract is published the first Monday of every month on the FTP server.

Consult the HMO Report Matrix for more information on this report and others at:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage

EOB 1103 The number of covered days is required.

EOB 1260 The sum of the accommodations days is not equal to the sum of covered plus non-covered days.

EOB 1103 sets with Edit 282 COVERED DAYS MISSING EOB 1260 sets with Edit 572 ACCOMM UNITS NOT EQUAL TO HDR DATE RANGE

Note: Effective 6/24/2014 Edit 572/EOB 1260 applies only to long-term care and long-term care crossover claim types.

Step 1 – Check 837 X12 for Covered Days in Header.

Covered days are indicated on the 837 with Value Code 80. Non-covered days is indicated with Value Code 81. Non-covered days could indicate a bed hold for long-term-care patients. When counting the DOS for inpatient or inpatient crossover encounters, the discharge date is not counted.

For DOS 6/14/2012 to 6/15/2012 there is one DOS. The sum of covered days and non-covered days equals the DOS.

Step 2 – Check 837 X12 for Accommodation Days in the Detail.

Assuming no breaks in admission, the covered days submitted in the header should match the days submitted in the accommodation detail(s). Accommodation revenue codes include:

Revenue From	Revenue To	Effective Date	End Date
0101	0180	1/1/1900	12/31/2299
0183	0183	1/1/1900	12/31/2299
0185	0185	1/1/1900	12/31/2299
0190	0194	1/1/1900	12/31/2299
0199	0219	1/1/1900	12/31/2299
1000	1005	1/1/1900	12/31/2299

Example 837I

CLM*8929694*8188***11>A>1**A*Y*Y~
DTP*096*TM*1800~
DTP*434*RD8*20120614-20120615~
DTP*435*D8*20120614~
CL1*3*1*01~
HI*BK>66131~
HI*BJ>V221~
HI*DR>373~
HI*BF>66331>>>>>>>Y*BF>V270>>>>>>>Y~
HI*BR>7359>D8>20120614~
HI* BE>80>>>1~
HI*BG>C1~
SBR*P*18*4444000******HM~
AMT*D*8188~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*A***MI*1419806416~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID HMO*****PI*69000000~
LX*1~
SV2*0110**1325*DA*1**0~
DTP*472*RD8*20120614-20120615~
REF*6R*8929694-34684741~
SVD*69000000*1325**0110*1~
DTP*573*D8*20120904~

EOB 0901 The from date of service and to date of service must be in the same calendar month and year.

EOB 0901 sets with Edit 577 SERV DATES ARE NOT IN SAME MONTH-DETAIL

On long term care encounters, the header from-date-of-service (FDOS) must be in the same month/year as the header to-date-of-service (TDOS). The detail FDOS must be in the same month/year as the header TDOS.

EOB 0051 The header from and to dates of service cannot be the same.

EOB 0051 sets with Edit 518 HDR DATES OF SERVICE CANNOT BE EQUAL

Note: EOB 0051 does not apply to Inpatient Crossover Claims (Claim Type A)

EOB 0051 will set on Inpatient Claims (Claim Type I) when the Header From Date-of-Service (FDOS) is equal to the Header To Date-of-Service (TDOS) except in the following cases:

- Revenue code 0720, 0721, 0722, 0724, or 0729 is present
- Patient status code is 02, 03, 04, 05, 20, 41, 62, 63, 64, 65, 66, 70, 82, 83, 84, or 85
- DRG related to MDC 14 [Pregnancy, childbirth and the puerperium]:
    - Claim was DRG priced and the MS-DRG is 765, 766, 767, 768, 774, or 775
      (Header TDOS prior to 01/01/2017 only)
    - Claim was DRG priced and the APR DRG is 540, 541, 542, or 560
- Header FDOS is equal to the Recipient Birth Date
  AND
  DRG related to MDC 15 [Newborns and other neonates with conditions originating in the perinatal period]:
    - Claim was DRG priced and the MS-DRG is 790, 791, 792, 793, 794, 795, or 998
      (Header TDOS prior to 01/01/2017 only)
    - Claim was DRG priced and the APR DRG is 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, or 640

EOB 0051 will set on Long Term Care Claims (Claim Type L) when the Header From Date-of-Service (FDOS) is equal to the Header To Date-of-Service (TDOS) except in the following case:

- Patient Status is 30

EOB 3059 ForwardHealth reimburses behavioral treatment services under this procedure code only when commercial insurance has previously allowed payment on the service. Resubmit this claim with the appropriate commercial insurance payment amount. If commercial insurance did not reimburse for this service, use the appropriate ForwardHealth-covered procedure code.

EOB 3059 sets with Edit 3783 OTH INS PAID RESTRICTION FOR PROC BILLING RULE

The following procedures have this restriction: 90791, 97532, H0031, H0032, H2012, H2014, and H2019.

The criteria for 'commercial insurance payment' is below.

- Other insurance payment of at least $0.01

AND/OR

- Submission of one or more of the following Adjustment Reason (American National Standards Institute - ANSI) codes for the detail on which the restriction is applicable:

    1. Deductible Amount
    2. Coinsurance Amount
    3. Co-payment Amount

See EOB 0278 for help on adding commercial insurance adjudication to the 837 X12 transaction.

Also see "Section 18.2 Submitting Encounters for Members with Other Insurance" of the *Encounter User Guide* for more information:
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spagehttps://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spage

EOB 0278 Member is covered by commercial health insurance on the date(s) of service.

EOB 0278 sets with Edit 2504 RECIPIENT COVERED BY PRIVATE INSURANCE

Note: EOB 0278 was turned on for encounter processing in July 2018.

Step 1 – Investigate commercial insurance coverage for the member on the DOS.

See Transaction 834 for member's other coverage. The HMO or provider contacts the other insurance carrier(s) for payment.

Step 2 – Add commercial insurance adjudication to the 837 X12.

Private payer is the primary payer. The private payer is identified by its carrier number or another ID. Claim filing indicator HM (SBR09) is used specifically in Wisconsin to represent Wisconsin Contracted HMOs submitting payment information as a prior payer on 837 HMO encounters. Private insurance, either proprietary or under the HMO organization umbrella, must choose a different value for this field when indicating commercial insurance as a prior payer on 837 HMO encounters. Claim filing indicator CI – Commercial Insurance would be an accurate value to represent private insurance.

The Medicaid HMO is the secondary payer. ForwardHealth is the tertiary payer. Potential private pay segments are added as an example.

837 Example

HL*830*172*22*0~
SBR*T*18*4444000******MC~
NM1*IL*1*LAST*FIRST*I***MI*1410048519~
N3*ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19630126*F~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*8689841*115***11>B>1*N*A*Y*Y*P~
HI*BK>30000*BF>311~
NM1*82*1*FROELICH
MD*RALPH***MD.*XX*1275558165~
PRV*PE*PXC*2084P0800X~
SBR*P*18*4444000******CI~
AMT*D*5~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*I***MI*1410048519~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*COMMERCIAL PAYER*****PI*092~
SBR*S*18*7025024******HM~
CAS*CO*223*115~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*I***MI*1410048519~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID
HMO*****PI*69000000~
LX*1~
SV1*HC>90862*115*UN*1***1>2~
DTP*472*D8*20120420~
REF*6R*8689841-33455095~
SVD*092*5*HC>90862**1~
CAS*CO*18*10~
CAS*PI*23*100~
DTP*573*D8*20120501~
SVD*69000000*0*HC>90862**1~
CAS*CO*18*10~
CAS*PI*23*105~
DTP*573*D8*20120503~

EOB 0962 Member does not have commercial health insurance for the date(s) of service.

EOB 0962 sets with Edit 2516 OTHER INSURANCE NOT ON FILE

Note: EOB 0962 was turned on for Encounter processing in July 2018.

The member does not have commercial insurance in the ForwardHealth database. The HMO can inform ForwardHealth of other insurance by completing the TPL discrepancy form on the MCO Portal.

EOB 1256 Member is enrolled in Medicare Part A on the date(s) of service.

OR

EOB 1257 Member is enrolled in Medicare Part B on the date(s) of service.

EOB 1256 sets with Edit 2500 RECIPIENT COVERED BY MEDICARE A EOB 1257 sets with Edit 2502 RECIPIENT COVERED BY MEDICARE B

Add Medicare insurance adjudication to the 837 X12.

Medicare is the primary payer. The Medicaid HMO is the secondary payer. ForwardHealth is the tertiary payer. Potential Medicare B payer segments are added as an example. SBR09 is MA for Medicare A, MB for Medicare B.

837 Example

HL*119*104*22*0~
SBR*T*18*4446002******MC~
NM1*IL*1*LAST*FIRST*P***MI*6424798161~
N3*ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19790226*M~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*8754642*309***23>B>1*N*A*Y*Y*P~
HI*BK>7821*BF>V0189~
NM1*82*1*SILVER MD*SARAH*S**MD.*XX*1396736740~
PRV*PE*PXC*207P00000X~
SBR*P*18*4446002******MB~
AMT*D*22.98~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*P***MI*6424798161~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICARE B*****PI*999~
SBR*S*18*4446002******HM~
AMT*D*22.98~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*P***MI*6424798161~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID HMO*****PI*69000000~
LX*1~
SV1*HC>99283*309*UN*1***1>2~
DTP*472*D8*20120409~
REF*6R*8754642-33799034~
SVD*999*22.98*HC>99283**1~
CAS*PR*2*130.00**3*120.00**1*36.02~
DTP*573*D8*20120501~
SVD*69000000*22.98*HC>99283**1~
CAS*CO*45*286.02~
DTP*573*D8*20120529~

EOB 1275 Quantity billed is restricted for this procedure code.

EOB 1275 sets with Edit 4163 QUANTITY RESTRICTION ON PROC BILLING RULE

Check Units Per Day & Diagnosis Restriction Report.

This report includes restrictions on procedure codes that include:

- Units allowed per date of service
- Diagnosis codes that must/must not be present when the procedure code is billed
- Procedure and/or revenue codes that must be billed with the service for it to be a covered

Search the report by Procedure Code. Note that the procedure may be listed under more than one contract. Select the applicable contract. Note restrictions for Claim Type, POS, Units per Day, Diagnosis Header Any, and Diagnosis Detail Any. Effective dates for the restrictions are also included.

For example, Search for Procedure 64487 under the OUTPA contract. Note the Units per Day restriction of 0-1. Units billed in excess of one do not meet the restrictions and will cause the encounter to deny.

The *Units per Day & Diagnosis Restriction Report* is published quarterly to the FTP server.

Consult the HMO Report Matrix for more information on this report and others at: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage.

EOB 0029 Last name does not match member ID.

AND/OR

EOB 0614 First name does not match member ID.

EOB 0029 sets with Edit 238 RECIPIENT LAST NAME IS MISSING EOB 0614 sets with Edit 237 RECIPIENT FIRST NAME IS MISSING

ForwardHealth matches the first two characters of the last name and first two characters of the first name of those submitted to the ForwardHealth database.

Due to a ForwardHealth system issue, HMOs do not submit a blank in the first two characters of the member's last name.

For example, O BRIEN should be submitted as OBRIEN.

EOB 0221 The detail billed amount is required.

AND/OR

EOB 1270 The header total billed amount is required and must be greater than zero.

EOB 0221 sets with Edit 268 BILLED AMOUNT MISSING EOB 1270 sets with Edit 270 HEADER TOTAL BILLED AMOUNT MISSING

Although zero is an EDI compliant value, it is not valid for pricing. HMOs submit a non-zero value for the header total billed amount and the detail billed amount.

Example 837

CLM*8753412*0***11>B>1*N*A*Y*Y*P~
HI*BK>30002*BF>29630~
NM1*82*1*SHELDON MD*EDWIN***MD.*XX*1427085737~
PRV*PE*PXC*2084P0800X~
SBR*P*18*4444000******HM~
AMT*D*0~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*N***MI*4406736948~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID HMO*****PI*69000000~
LX*1~
SV1*HC>99442>UA*0*UN*1***1>2~
DTP*472*D8*20120525~
REF*6R*8753412-33796848~
SVD*69000000*0*HC>99442>UA**1~
DTP*573*D8*20120531~

EOB 1271 The total billed amount is missing or incorrect.

EOB 1271 sets with Edit 508 BILLED AMT NOT EQUAL TO DTL BILLED AMT SUM

The header billed amount must equal the sum of the detailed billed amounts.

Example 837

CLM*BILLED AMT*898.00***13:A:1**A*Y*Y~
DTP*434*RD8*20130303-20130303~
CL1*3*1*01~
REF*4N*3~
HI*BK:6100~
HI*PR:6100~
NM1*71*1*MAZZA*JOSEPH****XX*1609972116~
PRV*AT*PXC*207R00000X~
NM1*82*1*KAMINSKY*MELISSA****XX*1225070188~
SBR*P*18*******HM~
AMT*D*8.00~
OI***Y***Y~
NM1*IL*1*LAST*FIRST****MI*9010002215~
N3*ADDRESS~
N4*MADISON*WI*537041234~
NM1*PR*2*HMO NAME*****PI*69000000~
LX*1~
SV2*0401*HC:77056:50:26:0A:0B:MAMMOGRAM BOTH BREASTS*220.00*UN*1.00~
DTP*472*RD8*20130303-20130303~
NM1*82*1*ONO*ERIKA****XX*1235108606~
SVD*69000000*4.00*HC:77056:50:26:0A:0B*0401*1~
CAS*OA*93*216.00~
DTP*573*D8*20130311~
LX*2~
SV2*0402*HC:76645:TC:26:0A:0B:US EXAM BREAST(S)*586.00*UN*1.00~
DTP*472*RD8*20130303-20130303~
NM1*82*1*ONO*ERIKA****XX*1235108606~
SVD*69000000*2.00*HC:76645:TC:26:0A:0B*0402*1~
CAS*OA*93*584.00
DTP*573*D8*20130311~
LX*3~
SV2*0401*HC:77051:50:26:0A:0B:COMPUTER DX MAMMOGRAM ADD-ON*92.00*UN*1.00~
DTP*472*RD8*20130303-20130303~
NM1*82*1*ONO*ERIKA****XX*1235108606~
SVD*69000000*2.00*HC:77051:50:26:0A:0B*0401*1~
CAS*OA*93*90.00~
DTP*573*D8*20130311~

EOB 1014 Service Denied due to 'N' financial indicator

EOB 1014 sets with Edit 3030 DTL FIN IND ASSIGNED IS 'N'; NOT PRICED

EOB 1014 sets if the detail financial indicator is 'N'. The financial indicator is determined by the HMO paid amount and the HMO shadow paid amount submitted on the encounter.

When a paid amount greater than zero is submitted at the header level, the header will receive a financial indicator of 'Y'. When a paid or shadow amount greater than zero is submitted at the detail level, the detail will receive a financial indicator of 'Y'.

A paid amount > 0 at the header level results in the header and all details receiving a financial indicator of 'Y' for Claim Types I, A, O, C, but not for Claim Types M, B, D, H, L.

A shadow amount > 0 at the header level results in the header and all details receiving a financial indicator of 'Y' for Claim Types I, A, O, C, H, or L but not CT M, B, D.

Claim Form	Claim Types	Type Description
Dental	D	Dental Claims
Professional	M	Professional
	B	Professional Crossover
Institutional	I	Inpatient
	O	Outpatient
	A	Inpatient Crossover
	C	Outpatient Crossover
	H	Home Health
	L	Long Term Care

For more information, refer to "Section 5.14: Financial and Utilization Logic" of the *Encounter User Guide:*
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Encounters_and_Reporting/Home.htm.spage

EOB 9956 Services have been carved out of HMO encounter processing.

EOB 9956 sets with Edit 3361 DENY ENCOUNTER FOR SVCS CARVED OUT OF MANAGED CARE

See Update 2014-79: Changes to Provider Administered Drugs Carve-Out Policy effective 1/1/2015 DOS.

Encounters for services that are carved out of encounter processing are denied. HMOs can find these carved out services in the HMO contract, Article III.E.1.

Encounter Types B, D, H, and M contain procedure codes that are not covered for the member benefit or assignment plans.

Encounter Types A, I, L, and O contain revenue codes that are not covered for member benefit or assignment plans.

Assignment plans may exclude services. For example, HMOMM (Medical) does not cover dental.

Several benefit plans are completely carved out of Managed Care:

- ADAP AIDS Drug Assistance Program
- AE Alien Emergency Services
- BCBAS BadgerCare Plus Basic Plan
- BCBEE BC+ Benchmark EE for Pregnant Women
- BCSEE BC+ Standard EE for Pregnant Women
- CRSW Community Recovery Services Waiver
- CTS State Supplemental Payment - Caretaker Supplement
- FC Family Care Non-MA
- FPW Family Planning Services Only
- MAPW Medicaid Purchase Plan Waiver <Waiver Medicaid>
- MCDW-Medicaid Waiver
- PE Presumptive Eligibility - Pregnancy Only
- QDWI Qualified Disabled Working Individuals
- QMB Qualified Medicare Beneficiary
- SC1 Senior Care Level 1- 0 to 200% FPL
- SC2 Senior Care Level 2- Over 200% FPL
- SLB Specified Low-income Medicare Beneficiary
- SLB+ Specified Low-income Medicare Beneficiary Plus
- SSI State Supplemental Payment - State Supplemental In
- SSIE State Supplemental Payment - State Supplemental In
- TB Tuberculosis Services Only
- WCDC Wisconsin Chronic Disease-Adult Cystic Fibrosis
- WCDH Wisconsin Chronic Disease-Hemophilia HomeCare
- WCDK Wisconsin Chronic Disease-Renal Disease
- WWMA Wisconsin Well Woman Medicaid
- WWWP Wisconsin Well Woman Program

Other services carved out of Managed Care include:

- Pharmacy
- Behavioral Health Integrated Care (BHIC)
- Behavioral Treatment – Autism Spectrum Disorders (BEHAV)
- Targeted Case Management (TCM)
- Residential Care Centers (RCC)
- Autism Diagnostic Confirmation
- Comprehensive Community Services (CCS)
- Crisis Intervention (MHCI)
- Community Recovery Services (CRS)
- Community Support Programs (CSP)
- Mental Health and Substance Abuse for Adults in the Home & Community (MHHC)
- Prenatal Care Coordination/Child Care Coordination (PNCC/CCC)
- School Based Services (SBS)
- High Cost Med Complx (HCMCR)
- Case Management (CSMGT)

EOB 0941 This procedure code and billed charge were rebundled to another code, which was either billed by the provider on this claim or added by ClaimCheck.

EOB 0941 sets with Edit 7217 PROCEDURE CODE HAS BEEN REBUNDLED

Encounters correctly recycle when ClaimCheck determines that the procedure should be bundled under another procedure code. While in the recycle status, the encounter will not appear on the encounter response report. The encounter will appear on a future encounter response report, most likely that of the next date. Adjudication will be included when the encounter is included on the encounter response report.

For more information on ClaimCheck, see Topic #644 of Online Handbook:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx

EOB 0679 The surgical procedure code of greatest specificity must be used.

OR

EOB 3052 Nonspecific ICD procedure codes cannot be used.

EOB 0679 sets with Edit 3322 ICD PROCEDURE CODE SPECIFICITY EOB 3052 sets with Edit 3408 NONSPECIFIC ICD PROCEDURE CODE

EOB 0679 sets on Outpatient, Outpatient Crossover, Home Health, Inpatient, and Inpatient Crossover encounters (includes Long Term Care Crossovers) if a surgical procedure code is submitted that is not specific.

EOB 0679 does not set on but on Long Term Care Encounters.

EOB 3052 sets on inpatient crossover if a surgical procedure code is submitted that is not specific enough.

For example, of the following ICD-9 codes, 8161 is not acceptable, but 8162, 8163, 8164 are acceptable.

- 8161: 360 SPINAL FUSION
- 8162: FUS/REFUS 2-3 VERTEBRAE
- 8163: FUS/REFUS 4-8 VERTEBRAE
- 8164: FUS/REFUS 9 VERTEBRAE

EOB 1347 Billing provider number is not found or not valid for dates of service.

EOB 1347 sets with Edit 1945 MULTI PROV LOCS FOR BILLING PROV SPEC - HDR

Note: Effective with date of submission 5/12/2015, additional provider logic was implemented for EOB 1347/Edit 1945. Please refer to "Section 5.8 Provider Matching and Usage Enhancements" of the Encounter User Guide for additional information.

When multiple service locations exist under one NPI, taxonomy and zip information is needed to determine the appropriate service location. EOB 1347 is returned when a unique billing provider cannot be determined. HMOs provide taxonomy and zip that match that of the provider in the ForwardHealth database.

EOB 1347 sets for providers with multiple NPIs. In the case of multiple NPIs, the system will first attempt to find a unique Medicaid ID by using taxonomy, if submitted. If a unique Medicaid ID cannot be found by using the NPI and taxonomy, the system will next look to the zip code to find a unique match. If a unique Medicaid ID cannot be determined, EOB 1347 will set. **If an NPI is submitted and exists only once in the system, the taxonomy and zip code match is not performed.** If a unique Medicaid ID is found using NPI and taxonomy, the zip code match is not performed.

PRV*BI*PXC*<taxonomy here>~
NM1*85*2*MERCY WALWORTH HOSPITAL AND MEDICAL*****XX*1699728550~
N3*1000 MINERAL POINT AVE~
N4*JANESVILLE*WI*500000000~

Professional and professional crossover encounters will initially suspend while a unique billing provider match is attempted. While in the suspend status, the encounter will not appear on the encounter response report. The encounter will appear on a future encounter response report, most likely that of the next week. Adjudication will be included when the encounter is included on the encounter response report. Other encounter types will deny without moving to a suspend status if a unique billing provider is not found.

EOB 1504 Performing provider number is not found.

EOB 1504 sets with Edit 1946 MULTI PROV LOCS FOR PERFORMING PROV SPEC – HDR EOB 1504 also sets with Edit 1952 MULTI PROV LOCS FOR PERFORM PROV SPEC - DTL

Note: Effective with date of submission 5/12/2015, additional provider logic was implemented for EOB 1504/Edit 1952. Please refer to Section 5.8 Provider Matching and Usage Enhancements of the HMO encounter user guide for additional information.

When multiple service locations exist under one NPI, taxonomy information is needed to determine the appropriate service location. EOB 1504 is returned when a unique performing provider cannot be determined. HMOs provide the taxonomy that matches that of the provider in the ForwardHealth database in the PRV Segment. Providers may update taxonomy on the provider portal.

Example 837

CLM*L333BHE00056*181***11:B:1*Y*A*Y*Y~
HI*BK:29572~
NM1*82*1*ROY*DONNA****XX*1922245604~
PRV*PE*PXC*<taxonomy here>~

EOB 0477 Billing provider indicated is not certified as a billing provider.

AND/OR

EOB 0175 Rendering provider indicated is not certified as a rendering provider.

EOB 0477 sets with Edit 1964 BILLING PROVIDER IS NOT DESIGNATED AS A "BILLER"
EOB 0477 sets with Edit 1956 NO BILLING PROVIDER LOCATION STATUS FOUND
EOB 0175 sets with Edit 1963 RENDERING PROVIDER IS NOT DESIGNATED TO RENDER

Note: EOB 0477/Edit 1964 will not set on professional, professional crossover, or dental encounters only processed after 3/4/2015.

A ForwardHealth provider is certified as either a 'Biller', 'Performer', or 'Biller and Performer'.

The submitted billing provider must be certified as a 'Biller" or 'Biller and Performer'.

The submitted performing provider must be certified as a 'Performer" or 'Biller and Performer'.

Note on Provider Propagation Logic

In some cases a billing provider is considered the rendering provider even if a separate rendering provider is submitted. In such cases, the rendering provider submitted is not used to price the encounter. Similarly, if a separate rendering provider is not submitted, the billing provider is also considered the rendering provider. In this case, the billing provider must be a 'Biller and Performer'.

See "Section 5.7: Provider Propagation Logic" in the *Encounter User Guide* for more information

EOB 0205 Detail Rendering Provider is no longer enrolled for the Date of Service

EOB 0205 sets with Edit 1047 PROVIDER TERMINATED - DTL PERFORMING

EOB 0205 sets when the detail rendering provider does not have a valid contract for the detail FDOS-TDOS span.

It is possible that a rendering provider may not have a valid contract for the entire date of service span at the time the encounter processed, but was then retroactively updated to cover these dates. If this is the case and records indicate that the provider is Medicaid certified for the dates of service, the encounter may not deny under this EOB upon resubmission.

This EOB only affects Dental, Professional, and Professional Crossover claim types.

EOB 1238 The rendering provider's taxonomy code in the header is invalid.

AND/OR

EOB 1491 The attending provider's taxonomy code in the header is invalid.

AND/OR

EOB 1505 The billing provider's taxonomy code in the header is invalid.

EOB 1238 sets with Edit 1901 TAXONOMY IS INVALID PERFORMING PROVIDER – HDR EOB 1491 sets with Edit 1916 TAXONOMY IS INVALID ATTENDING PROVIDER – HDR EOB 1505 sets with Edit 1900 TAXONOMY IS INVALID BILLING PROVIDER - HDR

The Healthcare Provider Taxonomy Code Set is maintained by the National Uniform Claim Committee and available from the Washington Publishing Company. It is the only code set that may be used in HIPAA standard transactions (including X12 837 transactions) to report the type/classification/specialization of a health care provider. All other taxonomy submissions are invalid.

EOB 0025 Billing or rendering provider enrollment is no longer enrolled for the From and/or To Date of Service.

AND/OR

EOB 0424 Billing provider ID is not on file.

AND/OR

EOB 1204 Billing provider is not certified for the date(s) of service.

EOB 0025 sets with Edit 1048 PROVIDER TERMINATED - DTL DOS
EOB 0424 sets with Edit 1000 BILLING PROVIDER I.D. NOT ON FILE
EOB 0424 also sets with Edit 1004 BILLING PROVIDER I.D. NOT ON FILE - DENY
EOB 1204 sets with Edit 1806 BILLING PROV NOT ELIG ON DTL DOS - OOS

Note: Effective with date of submission 5/12/2015, additional provider logic was implemented for EOB 0424/Edit 1000. Please refer to "Section 5.8: Provider Matching and Usage Enhancements" of the Encounter User Guide for additional information.

These EOBs are returned when a valid* NPI is submitted but there is no match in the ForwardHealth database, or no match for the DOS.

These EOBs often set when a provider uses an NPI that belongs to the provider but is not the NPI used to certify as a Medicaid provider.

**Valid NPIs meet algorithm or mathematical formula restrictions.*

EOB 9817 Billing provider number was used to adjudicate the service(s).

EOB 9817 is informational and does not have a corresponding edit.

Note: Effective with date of submission 6/21/2015, additional provider logic was implemented for EOB 9817. Please refer to "Section 5.7: Provider Propagation Logic" of the Encounter User Guide for additional information.

EOB 1599 Header rendering provider used as billing provider.

OR

EOB 1652 HMO hierarchy logic used to determine service location.

OR

EOB 1705 HMO hierarchy logic used to determine service location for detail rendering provider.

EOB 1599, EOB 1652, and EOB 1705 are informational and do not have a corresponding edits.

Note: Effective with dates of submission 5/12/2015 through 6/22/2015, additional provider logic was implemented. Please refer to "Section 5.8: Provider Matching and Usage Enhancements" of the Encounter User Guide for additional information.

EOB 1685 Billing provider type and specialty is not allowable for the place of service.

EOB 1685 sets with Edit 865 MH PT/PS 11/120, 11/121 HAS POS 11 BILLING RSTCN

Providers billing with provider type 11 (Mental Health and Substance Abuse) and provider specialty 120 or 121 (Licensed Psychotherapist or Licensed Psychotherapist with SAC) can only render services in Place of Service 11 or Place of Service 19 (effective on encounters with DOS on or after 1/1/2016).

EOB 3064 Services performed outside the four walls of a hospital are not reimbursable on an outpatient claim.

EOB 3064 sets with Edit 895 MODIFIER PO NOT ALLOWED ON OUTPATIENT CLAIMS

EOB 3064 sets if Modifier PO is submitted for any other NPI than 1922043744 and 1750482022.

Please refer to Update 2016-02 for more information on Forwardhealth's "4 Walls Policy".
Search for updates by year at:
https://www.forwardhealth.wi.gov/WIPortal/content/Provider/Updates/index.htm.spage

EOB 0378 Tooth number or letter is not valid with the procedure code for date of service.

AND/OR

EOB 0697 The number of tooth surfaces indicated is insufficient for the procedure billed.

AND/OR

EOB 1128 A tooth number or letter is required.

EOB 0378 sets with Edit 4211 TOOTH NUMBER/PROCEDURE CODE COMBINATION INVALID
EOB 0697 sets with Edit 266 INSUFFICIENT NUMBER OF VALID TOOTH SURFACE CODES
EOB 1128 sets with Edit 261 TOOTH NUMBER MISSING
EOB 1128 also sets with Edit 262 TOOTH NUMBER INVALID

Segment TOO identifies tooth number and surfaces for the procedure submitted.

Example 837

LX*1~
SV3*AD:D2150*45****1~
TOO*JP*12*L:O~

EOB 1145 Area of the oral cavity is required for procedure code.

EOB 1145 sets with Edit 4120 PROCEDURE CODE REQUIRES AREA OF ORAL CAVITY

Element SV304 identifies oral cavity for the procedure submitted.
An area of oral cavity code (01=Maxillary or 02=Mandibular) is required.

Example 837

LX*1~
SV3*AD:D1515*288.80*<oral cavity>*1**1~

EOB 1824 HMO ID is invalid or not present on encounter claim.

EOB 1824 sets with Edit 310 HMO ID INVALID

HMOs submit payment information on the encounter. The HMO is the second to the last payer, in this case the primary payer. Medicaid is the last payer, in this case the secondary payer.
The HMO Medicaid assigned ID is used to identify the Medicaid HMO payer.
Claim filing indicator HM (SBR09) is used specifically in Wisconsin to represent Wisconsin contracted HMOs submitting payment information as a prior payer on 837 HMO Encounters.

Example 837

HL*6*5*22*0~
SBR*S*18*******MC~
NM1*IL*1*LAST*FIRST*C***MI*5405777757~
N3* ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19960210*U~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*1450707A*45***11:B:1*Y*A*Y*Y~
DTP*472*D8*20120827~
SBR*P*18*******HM~
AMT*D*40~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*C***MI*5405777757~
N3* ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID HMO*****PI*69000000~
LX*1~
SV3*AD:D2150*45****1~
TOO*JP*13*M:O~
SVD*69000000*40*AD:D2150**1~
CAS*OA*45*5*1~
DTP*573*D8*20120928~

EOB 1644 Valid other payer date required.

EOB 1644 sets with Edit 3365 THE HEADER HMO DATE IS INVALID EOB 1644 also sets with Edit 941 THE HMO PAID DATE IS INVALID

HMOs submit their payment information on the encounter, including the date paid.

The HMO paid date must meet these restrictions:

- The paid date must be after the TDOS.
- The paid date must be before the ICN encounter date.
- The paid date must be in CCYYMMDD format.
- The paid date cannot be null or contain spaces.

Example 837

HL*6*5*22*0~
SBR*S*18*******MC~
NM1*IL*1*LAST*FIRST*C***MI*5405777757~
N3* ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19960210*U~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~
CLM*1450707A*45***11:B:1*Y*A*Y*Y~
DTP*472*D8*20120827~
SBR*P*18*******HM~
AMT*D*40~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*C***MI*5405777757~
N3* ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID HMO*****PI*69000000~
LX*1~
SV3*AD:D2150*45****1~
TOO*JP*13*M:O~
SVD*69000000*40*AD:D2150**1~
CAS*OA*45*5*1~
DTP*573*D8*20120928~

EOB 1668 Unable to processes your adjustment request. Claim ICN not found.

OR

EOB 1669 Unable to process your adjustment request. Original ICN not present.

OR

EOB 1672 Unable to process your adjustment request. Original claim ICN not found.

EOB 1668 sets with Edit 549 INVALID ADJUSTMENT TCN NOT FOUND EOB 1669 sets with Edit 551 INVALID ADJUSTMENT REQUEST HAS NO ORIGINAL ICN EOB 1672 sets with Edit 557 INVALID ADJUSTMENT ORIGINAL CLAIM NOT FOUND

When an encounter is being adjusted (CLM05-3 = 7) or voided (CLM05-3 = 8), the ICN being adjusted or voided is included in the REF Segment.

Example 837

CLM*12345678*200***11>B>8*N*A*Y*Y*P~
REF*F8*7013120001001~
REF*9C*7731293~
NTE*ADD*VENDOR RETURNED CHECK~
HI*BK>V7240~

Note: Only paid, active ICNs can be adjusted.

Once an ICN has been adjusted, that ICN cannot be adjusted again as it is no longer active.
For Example:

- Paid ICN A is adjusted by denied ICN B. ICN A can no longer be adjusted as it is not active. Active ICN B cannot be adjusted as it is denied. A new-day encounter is submitted.

- Paid ICN AA is adjusted by paid ICN BB. ICN AA can no longer be adjusted as it is not active. Active ICN BB can be adjusted.

EOB 1665 Unable to processes your adjustment request. Member ID not present.

OR

EOB 1670 Unable to processes your adjustment request. Member not found.

OR

EOB 1678 Unable to processes your adjustment request. Member ID number on the claim and on the adjustment request do not match.

EOB 1665 sets with Edit 546 INVALID ADJUSTMENT MEMBER MEDICAID ID NOT SUBMITT
EOB 1670 sets with Edit 552 INVALID ADJUSTMENT MEMBER NOT FOUND
EOB 1678 sets with Edit 564 INVALID ADJUSTMENT MEMBER IDS DO NOT MATCH

When an encounter is being adjusted or voided, the Member ID must be present and match the Member ID on the original encounter.

Example 837

HL*830*172*22*0~
SBR*T*18*4444000******MC~
NM1*IL*1*LAST*FIRST*I***MI*1410048519~
N3*ADDRESS~
N4*CITY*WI*500000000~
DMG*D8*19630126*F~
NM1*PR*2*FORWARDHEALTH*****PI*WISC_TXIX~

EOB 1667 Unable to processes your adjustment request. Provider ID not present.

OR

EOB 1671 Unable to processes your adjustment request. Provider not found.

OR

EOB 1679 Unable to processes your adjustment request. Provider ID number on the claim and on the adjustment request do not match.

EOB 1667 sets with Edit 548 INVALID ADJUSTMENT PROVIDER ID NOT PRESENT
EOB 1671 sets with Edit 553 INVALID ADJUSTMENT PROVIDER NOT FOUND
EOB 1679 sets with Edit 566 INVALID ADJUSTMENT PROVIDERS DO NOT MATCH

Note: EOB 1671 and 1679 are no longer enforced for encounters processed after 5/8/2015.

When an encounter is being adjusted or voided, the Provider ID must be present and match the Provider ID on the original encounter. An adjustment may contain an updated taxonomy as long as the Provider ID is present and matches the Provider ID on the original encounter.

Example 837

PRV*BI*PXC*<taxonomy here>~
NM1*85*2*MERCY WALWORTH HOSPITAL AND MEDICAL*****XX*1699728550~
N3*1000 MINERAL POINT AVE~
N4*JANESVILLE*WI*500000000~

EOB 1677 Unable to process your adjustment request. The claim type of the adjustment does not match the claim type of the original claim.

EOB 1677 sets with Edit 563 INVALID ADJUSTMENT CLAIM TYPES DO NOT MATCH

When an encounter is being adjusted, the encounter type of the original and adjustment must match. The best strategy may be to void the original encounter and submit another original encounter using the correct encounter type.

EOB 1673 Unable to process your adjustment request. Claim has already been adjusted.

EOB 1673 sets with Edit 558 INVALID ADJUSTMENT CLAIM HAS BEEN ADJUSTED

Once an original encounter has been adjusted, whether the adjustment denied or priced, the original adjustment cannot be adjusted again. In the case of a denied adjustment, the HMO submits another original encounter if the services need to be reported. A priced adjustment can be adjusted again.

EOB 1531 Indicator for present on admission (POA) is not a valid value.

EOB 1531 sets with Edit 851 POA CODE IS INVALID

Valid present on admission (POA) values are as follows:

- N: No
- U: Unknown
- W: Not Applicable
- Y: Yes

Example 837

HI*BF:36811:::::::Y*BF:67482:::::::Y*BF:64901:::::::Y*BF:V252:::::::Y*BF:V270:::::::Y~

EOB 0273 Resubmit charges for ForwardHealth covered service(s) denied by Medicare on a ForwardHealth claim.

EOB 0273 sets with Edit 452 CALCULATED DETAIL MEDICARE ALLOWED AMOUNT IS ZERO

If services covered by both Medicare and Medicaid are paid zero (denied) by Medicare, Medicaid also pays zero. If services are not covered by Medicare but are covered by Medicaid, Medicaid may price. Each category of service must be submitted as a separate encounter. To designate the services on the encounter are not covered by Medicare, include Loop 2320 Amt – Coordination of Benefits (COB) Total Non-Covered Amount.

In this example, Medicare paid $0.00 and the HMO paid $6.00 of the $39.00 total. Once Loop 2320 Amt – Coordination of Benefits (COB) Total Non-Covered Amount is used, the encounter must meet requirements of the non- crossover encounter type. For example, an encounter that would have been submitted as a professional crossover encounter if Medicare had covered, must now meet the requirements of a professional encounter.

Example 837

CLM*12240E000008*39.00***13:A:1**A*Y*Y~
DTP*434*RD8*20120731-20120731~
CL1*3*1*01~
HI*BK:25000~
HI*PR:25000~
HI*BF:36570*BF:37157:::::::U~
HI*BH:11:D8:20120731~
NM1*71*1*LAMB*GEOFFREY****XX*1962453712~
PRV*AT*PXC*282N00000X~
SBR*P*18*******MB~
AMT*A8*39.00~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*L***MI*9415708891~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICARE B*****PI*004~
SBR*S*18*******HM~
AMT*D*6.00~
OI***Y***Y~
NM1*IL*1*LAST*FIRST*L***MI*9415708891~
N3*ADDRESS~
N4*CITY*WI*500000000~
NM1*PR*2*MEDICAID HMO*****PI*69000000~
LX*1~
SV2*0300*HC:83036*39*UN*1.00~
DTP*472*D8*20120731~
SVD*69000000*6*HC:83036*0300*1.00~
CAS*CO*45*33~
DTP*573*D8*20120904~

EOB 1198 A National Drug Code (NDC) is required for this HCPCS Code.

EOB 1198 sets with Edit 870 HCPCS PROCEDURE REQUIRES A VALID NDC

The NDC for the procedure is identified in Loop 2410 Segment LIN.

Example 837

LX*1~
SV1*HC:A9579*59.8*UN*20***1~
DTP*472*D8*20121108~
REF*6R*2~
LIN**4N*NDCHERE~

EOB 0100 Denied as a duplicate claim.

EOB 0100 sets with Edit 5000 PROV PROC EXD M1 M2 M3 M4 B/QTY B/AMT - DENY
EOB 0100 also sets with Edit 5001 PROV PROC EXD M1 M2 M3 M4 B/QTY
EOB 0100 also sets with Edit 5003 PROV PROC EXD TOOTH NUMBER
EOB 0100 also sets with Edit 5004 PROV PROC EXD ORAL CAVITY/QUADRANT
EOB 0100 also sets with Edit 5005 PROV PROC EXD M1 M2 M3 M4 B/QTY
EOB 0100 also sets with Edit 5006 PROV PROC EXD M1 M2 M3 M4 B/AMT
EOB 0100 also sets with Edit 5007 SAME RPROV SAME PROC SAME DDOS - DENY
EOB 0100 also sets with Edit 5029 PROV AMT EXD - CLAIM TYPES EQUAL
EOB 0100 also sets with Edit 6934 PROV EXACT HEADER DATES OF SERVICE - DENY
EOB 0100 also sets with Edit 6935 SAME RPROV SAME PROC SAME DDOS
EOB 0100 also sets with Edit 6937 PROV PROC PD M1 M2 M3 M4 - DENY
EOB 0100 also sets with Edit 6938 ESRD SAME PROVIDER SAME DETAIL FROM DOS

Note: Effective 6/13/2015, the ICN causing the duplicate EOB is included on Record 600 of the Encounter Response File.

EOB 0100 indicates the encounter cannot be processed because similar or duplicate services have been at least partially paid already.

Possible variables causing EOB 0100 include:

- Encounter Type
- Billing Provider
- Performing Provider
- Procedure Code
- Procedure Modifier
- From Date of Service
- To Date of Service
- Billing Quantity
- Billed Amount
- Tooth Number
- Area of oral cavity

EOB 0363 This obstetrical service was previously paid for this date of service for this member.

EOB 0363 sets with Edit 5043 DUPLICATE OBSTETRICAL SERVICES

Although the wording on the EOB suggests a single date of service, the criteria actually monitors obstetrical care codes against office visit codes where there is a pregnancy on both encounters 270 days before and 42 after the obstetrical care codes. This enforces the policy that pregnancy-related office visits are included in the obstetrical care codes.

The following diagnosis codes are used to define a pregnancy-related office visit.

ICD-9	
Diagnosis Code Range From	Diagnosis Code Range To
630	677
V22	V221
V23	V242
V27	V289

ICD-10	
Diagnosis Code Range From	Diagnosis Code Range To
O000	O039
O0900	O2693
O29011	O30019
O30031	O356XX9
O358XX0	O368199
O368910	O9A53
Z3400	Z379
Z390	Z392

EOB 8188 MASS ADJUSTMENT – VOID TRANSACTIONS.

EOB 8188 indicates the encounter has been successfully voided. The encounter will be in a deny status.

EOB 3041 Submitting HMO is not the enrolled HMO of the member.

EOB 3041 sets with Edit 3367 SUBMITTING HMO IS NOT THE ENROLLED HMO OF THE MEMBER.

Edit 3367 will post when the submitting HMO provider is not the enrolled HMO provider of the member for the date(s) of service. With exception to inpatient encounters, the entire date-of-service span on each detail is checked.

For Inpatient and Inpatient Crossovers, the edit only checks the member's HMO enrollment on the Header from-date-of-service (FDOS).

EOB 9955 Member is not enrolled in managed care.

EOB 9955 sets with Edit 3362 RECIPIENT NOT ENROLLED IN MANAGED CARE PLAN

EOB 9955 sets when the member is not enrolled in an HMO assignment plan as of the detail FDOS/TDOS range.

There may be retroactive changes to a member's eligibility or HMO enrollment. If records indicate that a member is enrolled for FDOS/TDOS of an encounter that denied under EOB 9955, resubmitting the encounter may bypass the EOB.

EOB 1566 Denied/Cutback. One BMI Incentive payment is allowed per member, per rendering provider, per calendar year.

EOB 1566 sets with Edit 6269 INCENTIVE PAYMENT BMI 1 PER CAL YEAR/PER PROV

EOB 1566 will deny an encounter with procedure code 3008F [BODY MASS INDEX, DOCUMENTED] if the same procedure code paid on a previous encounter billed by the same provider, within the last year, for the same member.

EOB 1306 Add-on codes are not separately reimbursable when submitted as a stand-alone code.

EOB 1306 sets with Edit 1809 MONITOR OFFICE VISITS FOR BMI PAYMENTS

EOB 1306 sets if an encounter with procedure code 3008F [BODY MASS INDEX, DOCUMENTED] is not billed with an associated office visit code (99381-99385, 99391-99395, 99201-99205 and 99211-99215) on the same date of service.

EOB 1012 A patient status code indicating the member has expired is required when an occurrence code representing the members date of death is submitted. Or, The occurrence code for member date of death is not allowed to be billed as a span code.

EOB 1012 sets with Edit 4019 REPORT DOD WITH MEMBER EXPIRED PATIENT STATUS CODE

For Hospice Claims (Billing Provider Type 06 only), edit 4019 will set when:

- Occurrence Code 55 [Date of Death] is billed as an occurrence span(e.g. HI01-1 = BI , HI01-2 = 55)

OR

- Occurrence Code 55 [Date of Death] is billed (e.g. HI01-1 = BH, HI01-2 = 55)
  AND
  Patient Status Code (CL103) is NOT 20 [Expired -used only when the patient dies]

EOB 1686 This service is not payable with another service on the same date of service due to National Correct Coding Initiative.

AND

EOB 1690 Quantity indicated for this service exceeds the maximum quantity limit established by the National Correct Coding Initiative.

AND

EOB 1691 This service is not payable for the same date of service as another service included on the same claim, according to the National Correct Coding Initiative.

EOB 1686 sets with Edit 6300 CCI OPHOS DENY CURRENT - DIFF CLAIM EOB 1690 sets with Edit 4182 NCCI MUE OPHOS (National Correct Coding Initiative Medically Unlikely Edit Outpatient Hospital) EOB 1691 sets with Edit 4185 CCI OPHOS (Correct Coding Initiative Edit - Outpatient Hospital)

These EOBs only set on Outpatient claim types. These EOBs do not affect Outpatient Crossovers.

Forwardhealth uses a required subset of edits from the National Correct Coding Initiative (NCCI) followed by Medicare. There are two types of NCCI edits:

1. Procedure to Procedure (PTP) Edits: These edits define pairs of HCPCS/CPT codes that shouldn't be reported together. Claims with these pairs billed will be denied.
2. Medically Unlikely Edits (MUEs): These edits define maximum units of service that would be normally reported under most circumstances.

A complete list of these edits can be found here:

https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

EOB 3012 This service cannot be performed in an outpatient hospital setting.

EOB 3012 sets with Edit 4352 EAPG GROUPER EDIT -SVC CONSIDERED INPATIENT PROC. CT O AND C

EOB 3012 sets on outpatient and outpatient crossover claims that use the EAPG pricing methodology. Procedure codes that cannot be performed in an outpatient hospital setting are outlined in Topic #15297 of the Online Handbook:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx

- Choose a Program: BadgerCare Plus and Medicaid → Choose service area: Hospital, Outpatient → Select Covered and Noncovered Services → Codes → Procedures Reimbursable Only as Inpatient Hospital Services

A claim containing one of these procedures will be denied in its entirety.

EOB 3018 Detail denied because a related significant procedure and/or medical visit was denied for the same visit.

EOB 3018 sets with Edit 4360 EAPG GROUPER: PURPOSE FOR VISIT WAS DENIED

The EAPG system classifies EAPGs into one of the following types:

- Significant procedure — a normally scheduled procedure that **constitutes the reason for the visit and dominates the time and resources expended during the visit**.
- Medical visit — a visit during which medical treatment was received but no significant procedure was performed. One example of a medical visit would be a preventive care visit.
- Ancillary service — the term "ancillary service" is used to refer to both ancillary tests and ancillary procedures. Most ancillary services are packaged into an EAPG rate for a significant procedure or medical visit, and are not separately reimbursable.

For claims processing with EAPG, if all of the significant procedure codes billed on the claim are denied, Forwardhealth will deny any remaining details with EOB 3018. To identify the cause of the denial, look for details denying under EOBs other than 3018.

Error 4360 will set on any outpatient claim where ALL significant procedure codes and/or medical visits for a given visit are denied. Note that a claim may contain strictly ancillary services without any significant procedure codes and pay. That is to say the edit only denies ancillary services when:

1) There are significant procedures (EAPG types 02, 03, 21, 22, 23, 24, or 25) and/or medical visit (EAPG 491) details present

AND

2) These details all deny for other reasons.

If a claim does contain multiple visits (details with different dates-of-service), the EAPG software will separate each visit and assign it a ***visit ID.*** The edit sets on a visit ID basis, so it will only deny the services associated with that visit, i.e. not the entire claim.

Please note that if an emergency revenue code is billed anywhere on the claim, all details on the claim will be considered the same visit, regardless of date-of-service. ForwardHealth emergency revenue codes are: 0450, 0451, 0452, 0456, 0459 and 0762.

Relevant ForwardHealth Handbook Topics:

15217 – EAPG Reimbursement Methodology

15258 – Billing Under the EAPG System

EOB 3019 Services for this date of service have been previously paid. Providers may adjust a previously paid claim for this date of service to request reimbursement for additional services provided during the same outpatient hospital visit.

EOB 3019 sets with Edit 6939 EAPG DUPE OUTPATIENT HOSPITAL CT O AND C

Note: *For encounters, EOB 3019 does not affect Outpatient Crossovers.*

EOB 3019 sets when a second encounter is received for the same detail date of service of a previously paid claim.

For multiple unrelated medical visits with the same DOS, HMOs should use condition code "G0" and bill the visits on separate claims. The EAPG software is able to identify separate visits on the same DOS only when they are submitted on separate claims.

For multiple medical visits with different DOS, HMOs may bill more than one visit on a claim. The EAPG software treats details with different DOS as separate visits unless certain revenue codes (e.g. 045X, 0762) are used.

Enter a single DOS per detail line; ForwardHealth recommends avoiding range dates at the detail level on claims. This may involve splitting a single detail with range dates into separate, unique details. The EAPG software recognizes only the first, or "from," DOS at the detail level. **The claim may be priced inappropriately and reimbursement may be less than expected if range dates are used**.

Source: ForwardHealth Update October 2012-55